The Limitations of Dialectical Behaviour Therapy and Psychodynamic Therapies of Suicidality from an Existential-Phenomenological Perspective

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Abstract

Suicidality, a significant problem in New Zealand for the past decade or so, has invited a substantial body of research into causes and prevention. However, given the effort, the prevention results do not appear to be sufficiently convincing when coroners' views are considered. This paper focuses on two mainstream therapeutic approaches towards persons with borderline personality disorder, in which suicidal behaviour is a prominent feature demanding understanding and active attention. It is argued that dialectical behaviour therapy and psychoanalytically informed therapies are lacking on two accounts. Firstly, the philosophical and methodological underpinnings of both approaches perpetuate what Heidegger refers to as the compound misunderstanding of ourselves as human beings. Secondly, what this translates into is a practice which forgets the human order and misunderstands the experience of the singular human present in despair. As an alternative approach towards dealing with suicide in practice, the author presents concepts central to Heidegger's phenomenology of human existence and discusses how these may inform and enhance the treatment of suicidal patients.

Introduction

For the past decade or so, suicide has been a chronic problem in New Zealand which has invited considerable research into causes and prevention, and is considered to be one of thirteen health priorities for the Ministry of Health (Beautrais, 2000a, 2000b, 2001; Beautrais, Collings, Ehrhardt, & Ehrhardt, 2005; Beautrais, Joyce, & Mulder, 1998; Disley & Coggan, 1996; Ministry of Health, 2001, 2004, 2006a, 2006b). Warwick Holmes, a coroner, is reportedly troubled that New Zealand does not appear to be making any progress with preventing suicide amongst young men. He advocates that more attention be paid to the problem (*The Dominion Post*, 2006). But how have we been paying attention to date? Our quantifying questions seem to conceal rather than reveal, and in our practice we seem to have forgotten the 'who' that is suicidal.

The Royal Australian and New Zealand College of Psychiatrists has this to say in its guidelines to reduce deliberate self-harm: "Cognitive-behavioural therapy (CBT) and problem-orientated approaches appear promising for reducing repeated self-harm for most patient groups but no single treatment has confirmed superiority. Dialectical behaviour therapy (DBT) appears to confer most benefit" (Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003, p. 150). Dialectical behaviour therapy and cognitive behavioural therapy seem to be the preferred forms of treatment for suicidality in New Zealand. I will consider these approaches and also briefly consider psychodynamic therapies. All these approaches, however, have significant limitations from an existential-phenomenological perspective.

Heidegger (1927/1962) says that understanding

precedes interpretation, that doing understands. The problem with dialectical behaviour therapy and psychodynamic therapies is that there is a disjunction between understanding and doing. This disjunction is, according to Needleman (in Binswanger, 1975), the result of "incompatible conceptual horizons" of understanding. To highlight this, I will discuss concepts central to Heidegger's phenomenology of human existence and consider their capacity to inform and enhance the treatment of suicidal patients in a manner which does not forget *who*.

Most research into the mechanisms of change of various therapies focuses on the diagnostic category of borderline personality disorder (BPD) (Clarkin & Levy, 2006). This diagnostic group is identified by, inter alia, the prominent and perplexing symptom of parasuicidality. Parasuicidal behaviour is predictive of suicidality, and patients who have borderline personality disorders have an estimated suicide completion rate of between 8% and 10% (Levy et al., 2006). Suicidality is considered to be the result of two core personality traits that characterize much of the phenotypic variations seen in BPD - impulsivity and negative affectivity/emotional dysregulation (Clarkin & Levy, 2006).

Dialectical Behaviour Therapy (DBT) / Cognitive Behaviour Therapy (CBT) and Suicidality

According to cognitive theory, dysfunctional beliefs stem from negative learning experiences in childhood. These beliefs endure into adulthood, are inflexible in nature, and lead to cognitive distortions. It is hypothesized that the principal mechanism for change in cognitive therapy is the modification of dysfunctional beliefs, and the results of one open clinical trail report significant decreases in suicide ideation (Wenzel, Chapman, Newman, Beck, & Brown, 2006). Focusing almost exclusively on helping patients to change their thoughts, feelings and behaviours is often not palatable to BPD patients, and awareness of this led to Linehan's development of dialectical behaviour therapy (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006).

It is now well established, according to some researchers, that dialectical behaviour therapy (DBT) is perhaps the most "specific effective psycho-therapeutic intervention" to reduce "life-threatening impulse-control disorders" such as borderline personality disorder, in which suicide is a significant feature (Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003; Goldney, 2005; Linehan, Heard, & Armstrong, 1993; Lynch et al., 2006; Verheul et al., 2003).

Linehan's thesis is that "borderline individuals are emotionally vulnerable as well as deficient in emotional modulation skills, and that these difficulties have their roots in biological predispositions, which are exacerbated by specific environmental experiences" (1993, p. 43). Her approach applies a wide range of cognitive behavioural techniques to the treatment of the borderline personality disordered person, with an overriding emphasis on dialectics, defined as "the reconciliation of opposites in the continual process of synthesis" (1993, p. 19).

Perseius, Öjehagen, Ekdahl, Åsberg, & Samuelsson (2003) set out to determine how dialectical behaviour therapy is perceived by both patients with borderline personality disorder and their DBT therapists. The study concluded that dialectical behaviour therapy resulted in a significant decline in suicidal attempts and acts of self-harm. The patient participants attributed this to experiencing respect, understanding and confirmation from the DBT therapists. In addition, they considered the DBT skills crucial in conquering suicidal and self-harm impulses. The therapist participants concurred with these findings in their narrative accounts. In addition, the therapist participants attributed the success of the DBT approach to the "theoretical underpinnings" and "the therapeutic techniques", holding that "the personality of the therapist is of minor importance". The therapists also felt that it was critical to adhere to the therapeutic manual and stated that failures occur when therapists "don't stick to the manual" and work "by 'their own heads'" (Perseius et al., 2003, p. 224).

A major inadequacy, from an existential-phenomenological perspective, is that DBT does not provide insight into what suicidality means for the participants or how they experience and understand this phenomenon in treatment. From the preceding outline, it should be clear that, in Linehan's view, BPD patients who commit suicide are predisposed to do so due to biological and genetic factors as a first cause. Environmental factors merely exacerbate what has already been determined in the constitution of a person as an organism. This understanding in practice is clearly in violation of Linehan's own philosophical principle of "wholeness" (Linehan, 1993). There is no evidence of a true synthesis in understanding the *what*, *how* and *who* of human existence, that is, Being-in-the-world (Binswanger, 1958). The theory and description of an organism determines a different relationship to the theory and description of a person (Laing, 1965). This disjunction between intention and practice in DBT is prevalent in the rationalist positivist philosophy and epistemology that dominates the field of psychiatry and scientific psychology.

In what has now come to be widely referred to as "evidence based practice", standard behavioural modification techniques appear to be successful regardless of the phenomenon of intent. They are claimed to be successful with suicidal individuals, and equally successful with all the syndromes that fall within the diagnostic parameters of anxiety and depression, according to a number of researchers (Beck, 1976; Beck & Emery, 1985; Beck, Rush, Shaw, & Emery, 1979; Heimberg, 1993; Meichenbaum, 1977; O'Leary & Wilson, 1975; Rush, 1982; Zinbarg, 1993). Reliance on technique-driven therapies, and the application thereof across a disparate range of phenomena, suggests two things. Firstly, the person is not primarily understood in his or her specific life-world, but made to fit the theoretical representation of being human. Secondly, technique-driven therapies reflect upon the attitude brought to the relationship by the therapist, and as such represent intent. The therapist no longer "trusts what meets the eye and the ear", says Cohn (2002), and needs to devise interpretive means to decipher phenomena. Therapists no longer trust what the person present has to say, and have come to distrust the adequacy of their understanding by virtue of their own humanness. But how do two nobodies meet one another as somebody? "My thesis is limited to the contention that the theory of man as a person loses its way if it falls into an account of man as a machine or man as an organismic system of it-processes" (Laing, 1965, p. 23).

The aforementioned research by Perseius et al. (2003) further strengthens the argument that scientific psychology is divided in its intent and practice, considering a person as a behaving organism and relating to him as a person. This creates confusion and doubt when matching the intent of research with its outcome. In that study, the patients attributed the success of dialectical behaviour therapy to feeling respected and understood. Yet the therapists attributed the success of treatment to the "minor importance" of their personalities as therapists and claimed that failure occurs when therapists work "by their own heads" and fail to "stick to the manual". I cannot say how manuals of treatment impart an understanding of another person, other than in a vaguely aggregate manner, and even that is debatable. How is it possible to be understood by another person when that person, honouring the methodology of natural science, consciously and deliberately presents him or herself as an objective entity that administers a pre-designed procedure to address the plight of a singular person present? In my view, it would seem that the success of dialectical behaviour therapy for suicidality is not attributable to what therapists consciously do, but rather the result of what they think they deliberately do not do. They seem to have a therapeutic effect despite themselves. If this kind of self-deception is the case, then how is it possible to know why a particular activity has a certain effect? This telling oversight clearly demonstrates the phenomenologist's challenge to the validity and reliability of research where the researchers do not consider their personal contribution to the research process and outcome, and believe that they are "dispassionate observers". It brings doubt to the claim that dialectical behaviour therapy is the most specific affective psycho-therapeutic intervention to reduce life threatening impulse-control disorders when the reason for its effectiveness is so misunderstood. That DBT therapists have a therapeutic effect despite themselves illustrates, I believe, the Heideggarian notion of "language as Being-with". There appears to exist a fundamental understanding for the patient of which the therapist is unaware, an understanding forgotten by a mind imprisoned by the cookbook-like dictates of scientifically inspired treatment manuals and the procedures of "evidence based practice". "The existential-ontological foundation of language is discourse or talk", and discourse "is existentially equiprimordial with state-of-mind and understanding" (Heidegger, 1927/1962, p. 203). Our communication does not start with hearing any words, but with attunement-with and understanding-with. It is Heidegger's contention that both talking and hearing are based upon understanding. This understanding does not arise through talking and hearing, because only "he who already understands can listen" (Heidegger, 1927/1962, p. 208). Language makes understanding explicit; it manifests what is originally understood. Heidegger seems to be suggesting that our primordial listening-with and our understanding-with are an ineffable experiencing with another, and that language is an approximation of this experience. The world we share with others as meaningful speaks to us before words are used, says Cohn (2002).

The self-deception evident in the aforementioned research resonates with Heidegger's view of the compounded misunderstanding of Dasein. "The Self of everyday Dasein is the they-self, which we distinguish from authentic Self - that is, from the Self which has been taken hold of in its own way" (Heidegger, 1927/1962, p. 167). Our fundamental way of being is they-Being, and in this way we are fundamentally historical. The human being is always thrown into a historical world and has to come to its own interpretation of world out of this historical context. Because we deal with things in this 'they' way, Dasein is fundamentally self-misinterpreting. It is not that we have the wrong theory of ourselves or that we read too much Descartes. It is rather that,

because we start off as 'they', we interpret things in an inauthentic way, including our own Being. This misunderstanding is compounded by the sciences, and the human sciences in particular, which make the 'categorical error' of interpreting the nature of being via categories of knowledge such as psychology, anthropology and theology. These categories of knowledge fail to do justice to an understanding of human existence. These categories do not take the existence of Dasein into full account, says Heidegger. "We must rather choose such a way of access and such a kind of interpretation that this entity can show itself in itself and from itself" (1927/1962, p. 37).

At the heart of cognitive and behavioural therapies lies the Cartesian-inspired notion of "a mind" that exists without a world. The mind can have thoughts and feelings regardless of the world - I think therefore I am. Whilst this is one mode of Being (as a categorical structure of existence), it is not the Being of Dasein. Whether Dasein exists authentically or inauthentically, the character of this existence must be understood a priori as grounded in a state of Being that Heidegger (1927/1962) refers to as Being-in-the-world. This compound expression indicates a unitary phenomenon. Human existence is grounded in our always already finding ourselves in the world. Dasein exists (ek-stasis) outside itself. There is no inner or outer. "The Dasein which knows remains outside, and it does so as Dasein" (Heidegger, 1927/1962, p. 89). Inner and outer explains something about Dasein as a categorical structure of knowledge, insofar as it offers a theoretical understanding of being human, but it does not give an ontological explication of the Being that exists - the 'who' that is knowing.

To "exist as Dasein means to hold open a domain through its capacity to receive-perceive the significance of the things that are given to it [Dasein] and that addresses it [Dasein] by virtue of its own 'clearing'" (Heidegger, 2001, p. 4). Heidegger is emphatic that human existence cannot be objectified, because the significance of things received-perceived is such by virtue of human existence in itself. There is no subject to be separated from an object. The existence of both is interdependent. Without one, there is no other, and in therapy there thus cannot be an object (therapist) and a subject (patient), nor an 'inside' subject, nor experiences that can be measured or encapsulated by theoretical representations, without forgetting that the world of a therapeutic encounter is the 'clearing' where the significance of what is received-perceived is laid bare for the first time by Being-with one another. It is for this reason that aggregating methods and techniques of therapy are unsuited for the purpose within the context of existential therapy, because 'method and technique' are born in each unique 'clearing' of Being-with. A therapy designed to treat suicidality with a certain method because it correlates with a predetermined factor, violates a basic structure of human existence, and thereby fails to render a sound understanding of what it may mean to be suicidal.

Psychodynamic Therapies and Suicidal Behaviour

According to psychoanalytic theory, suicide is a self-destructive act aimed at an "introjected object" or the result of the "death instinct" (Rycroft, 1972). Rycroft defines introjection as occurring when an external object is made into a mental representation and the relationship with the object 'out there' is replaced by one with an imagined object 'inside'. Whilst "no biological observational can be found to support the idea of a death instinct" (Rycroft, 1972, p. 27), it is postulated in psychoanalytic theories that all organic life shows a tendency towards breaking down into more simple forms (Kruger, 1979). May (1977) suggests that Freud was probably struggling with the concept of existential anxiety when he postulated the death instinct in conflict with the life instinct.

Suicide, in the psychoanalytic tradition, is closely associated with aggression, a derivative in service of "the two great primary instincts of man: hunger and love" (Riviere, 1967, p. 3). Kernberg (1975) suggests that suicidality occurs in those who have yet to resolve preoedipal conflicts. It is a developmental stage dominated by the undifferentiated impulses (instincts) of primitive aggression and sex: the giving and taking of life in service of self-preservation. Due to this 'primitive' character structure, a person responds with indiscriminate aggression towards others or himself (self-mutilation and suicidal acts) when gratification of these impulses is frustrated. This postulated impelling behaviour seems to inform Kernberg's statement about the treatment of BPD that a person may use "threats of suicide to control his environment (including the psychotherapist)" (1975, p. 90). Suicide is thus a means intended to manipulate the world to derive satisfaction. It is seen as an impulsive aggressive act in retaliation to frustration. David Malan (1979) suggests that suicide may be the outcome of the psychological impasse when anger and guilt or anger and love are 'fused'. The inability to differentiate and locate the aim of these opposing feelings causes psychic pain which is often resolved through suicide. Suicide thus seems to be caused by a mood of some unresolved frustration.

Our attunement or state-of-mind is one of the structures which are definitive of human existence. Heidegger suggests that moods are not something below the level of disclosure or truth or how the

world comes to us, but something quite fundamental. And we are always, he says, in some mood. Mood determines the way in which things come to us out of the world and how it is disclosed; it is what allows the world to matter. "A mood makes manifest 'how one is, and how one is faring'. In this 'how one is', having a mood brings Being to its 'there'" (Heidegger, 1927/ 1962, p. 173). To articulate this sense that mood is primordial and beyond rational control, that one discovers oneself in some sort of mood at a given time, Heidegger employs the term "thrownness" and "being delivered over". We do not know the 'whence' or the 'whither' of our mood, merely the fact that we find ourselves thrown there. In mood, Dasein is disclosed to itself "prior to all cognition and volition, and beyond their range of disclosure" (Heidegger, 1927/1962, p. 175). Phenomenologically speaking, we will fail to recognize what the mood discloses and how it discloses if we attempt to explain what Dasein knows and believes, or is acquainted with at the time of a particular mood, says Heidegger. In other words, seeking a rationale for something that is by nature irrational is to not see it at all. Kernberg's reason for the dark mood of anger which may lead to suicide is that it spells the beginning of reason that does not see at all.

More recent literature suggests that psycho-analytically informed therapies are successful in treating suicidality. After a year of twice weekly psychotherapeutic treatment of 30 patients diagnosed with BPD, Stevenson and Meares (1992) report a significant improvement in key diagnostic indicators, such as self-harm and suicidality. Bateman and Fonagy (2001) report a similar result in their study of BPD patients who completed a psychoanalytically orientated partial hospitalization programme. According to Kernberg (1975), BPD patients have difficulty integrating disparate representations of themselves and others because negative emotions, such as aggression, disrupt their capacity to integrate these partial representations. "Strong, unmetabolized or unprocessed emotions have the capacity to overwhelm positive representations", says Kernberg (Levy et al., 2006, p. 484). This idea of a lack of conscious differentiation, which is at the heart of the BPD syndrome, is also evident in Malan's (1979) view to understanding and treating suicide when associated with depression and aggression. According to him, depression and aggression can be therapeutically treated by 'working through' the depressive position - a term coined by Klein (1934), and extensively rearticulated by Winnicott, to describe the realization that love and hate are directed towards the same person. This lack of differentiation and integration of internal images of self and others is called identity diffusion (Levy et al., 2006).

An equiprimordial constitutive of Dasein is understanding. Understanding doesn't mean here a kind of cognizing in the sense that Kant would use it, or Kernberg with his "patients that are having difficulty integrating disparate representations of themselves"; it is not some particular competence to carry out some given task, but rather Dasein's own competence in Being as such. It is not that we first exist and then later understand some things; our existing is a matter of understanding world. Dasein is thrown into the world of 'they'. It is not a world of its choosing, nor is it a world where it can predict what is revealed. "And in so far as understanding is *accompanied by* state-of-mind and as such is existentially surrendered to thrownness, Dasein has in every case already gone astray and failed to recognize itself" (Heidegger, 1927/1962, p. 184). In Kernberg's treatment approach, as in Malan's, the patient's misunderstanding of Being is not illuminated, because it lies at the unexplored ontological level. Dasein's competence to be itself and project itself into its own future possibilities is taken from the 'they'. Its potential to be itself is, therefore, to find its own possibilities in the possibilities of thrownness. This misunderstanding in psychodynamic therapies will continue, with feelings being split-off from their context and seen as repressed or set aside, waiting for expression; with the idea that childhood can be re-experienced in its original purity and context; with the idea of a purely cognitive approach to problems and the superiority of rationality. This propensity in Western thinking cannot be maintained without losing touch with what it is to exist as a human being (Cohn, 2002).

Based on Kernberg's object relations model of BPD, Transference Focused Therapy has shown a reduction in suicidality and anger (Levy et al., 2006). Persons with BPD have a "split psychological structure" where "negative representations are split/segregated from idealized positive representations of self and others", says Kernberg (Levy et al., 2006, p. 486). The putative global mechanism of change is the integration of these "object relations dyads" into a more coherent whole. This increased coherence results in a greater capacity for intimacy and reduction of self-destructive behaviours. From the therapist's point of view, the mechanism of change consists of a structured treatment approach, using a treatment manual, clarification, confrontation and interpretation. Technical application of clarification, confrontation and interpretation is a recognized therapeutic method in most psycho-analytically informed psychodynamic therapies (Davanloo, 1978; Golden, 1978; Malan, 1978, 1979; Mann, 1978; Sifneos, 1978; Straker, 1978; Strupp, 1978; Yung, 1978). The method rests on the theory that problems

have their origin in the past and are repeated, or inappropriately transferred into the present, until satisfied.

Heidegger conceives of time as quite different from the mainstream conception of time as linear and calibrated as something we 'have' as a past, present and future. In his *Being and Time* (1927/1962), Heidegger claims that time is Being. We can only measure time because we already have such a thing as time, says Heidegger. The literal meaning of existence is "to stand out", thus implying that human existence transcends its immediate situation. Cohn (2002) says that time is not a thread but a web which refers simultaneously to what is, what has been and what is to be. Our understanding of ourselves is imbued by all three dimensions all the time and defines our being. The present can therefore not be causally explained by past and future, nor is there a need for the 'unconscious' in which the past is waiting for expression. The past and the future are being expressed continually in our decisions and understanding of ourselves. Existential therapy focuses on the possibilities of existence, chosen in the light of our 'givens', such as mortality, being-in-the-world, being-with-others and being-in-a-body. It is possible to choose differently, despite the givens of existence. Existential therapy aims to bring this home to the client with its proposition that the future, in contrast to the present or past, is the dominant mode of time for human beings (May, 1958).

The technique of interpretation is, by all accounts, a learned and complex skill (Davanloo, 1978; Freud, 1910/1962, 1979; Golden, 1978; Kernberg, 1975; Malan, 1978, 1979; Mann, 1978; Sifneos, 1978; Straker, 1978; Strupp, 1978; Yung, 1978). There appear to be so many things to consider whilst in a therapeutic conversation with another. In making an interpretation of the purportedly hidden content of an unfolding story, the therapist has to consider a variety of secondary constructs of understanding: defence mechanism or impulse? past conflict or present one? transference in vivo or with others outside? and so forth (Malan, 1979). The essence of a transference interpretation is that "the therapist does not respond to the patient's fragmented one-dimensional partial representation but helps the patient observe it and the implied other that is paired with it" (Levy et al., 2006, p. 488).

Being-with means that the individual can never be understood in isolation as in the aforementioned Cartesian-inspired conception of two independent subjects 'relating' to one another in a physical space, each with his or her own ideas and respective consciousness of the other. My being here and you being there is not being-with. Being-with is to "sojourn with you in the same being-here … not a relationship of a subject to another subject" (Heidegger, 2001, p. 112). Heidegger's Being-with is thus referring to an existential relatedness which precedes any kind of particular relationship, such as, for instance, an empathic relationship or a transference relationship. Ontologically, we cannot but 'be with' others, but how we do this is another matter, says Cohn (2002). The concept of 'care' is a summary of the existential structures of Dasein and refers to the concern of Dasein for itself and for another Dasein. A particular mode of care - a deficient one - is relevant to mention here: that mode of care in which it 'leaps in' for the other. It takes over for the other in therapy that supports clients by the giving of advice and medication (Cohn, 2002). The kind of care - also a deficient mode - more attuned to the philosophy of existential therapy, is a care that 'leaps ahead' of the other, "not in order to take away his 'care' (of his own Dasein) but rather to give it back to him authentically for the first time" (Heidegger, 1927/1962, p. 159). Therapeutically, the concept of being-with suggests a more direct communication between therapist and client, where there is no need for the mediating scaffolds of representations, projections or transference to understand and be-with what meets the eye and the ear. The with-world is "a world of context, connections, mutuality and change in which you cannot 'pin-point' anything or look for single causes, specific origins and unique events" (Cohn, 2002, p. 41).

A most striking feature of the psychodynamic method is the highly technical language and theoretical concepts which refer to a multilayered hypothesis of human reality - which, when defined, amounts to what Todres (2002) describes as the depersonalization of the human order through objectification, compartmentalization and specialization. It raises the question whether a human encounter is possible where the therapist - as sole expert of mystifying lexicon and conceptualization of being human - constricts the freedom to explore and understand experiences as they unfold in conversation. So many presuppositions, assumptions, judgments and compartmentalizations cannot but obscure and conceal what is actually before the therapist and the client. It is also questionable whether a spontaneous and authentic human encounter between two whole people is possible when they become 'observers' of the 'partial representations' of one of the observers suffering 'unmetabolized emotions', in order to integrate the 'object relations dyads' that purportedly belong to the 'split psychic structure' of this fellow observer. It seems to me that psychoanalytic theory in

its practice has achieved what all the King's horses and all the King's men for so long have failed to do. Through meticulous naming, ordering and classification, things have been put together once again. Is it, however, Humpty Dumpty?

It is the therapeutic relationship that is the most important and overriding factor in the treatment of suicidal people in all forms of therapy (Leenaars, 2006; Michel, Dey, Stadler, & Valach, 2004; Reeves & Seber, 2004). The traditional medical model leaves the needs of suicidal patients unmet through an experience-distant encounter. The therapist is the sole expert. The model is linear and causal; regrettably, people - and, for that matter, nature - are not (Leenaars, 2006).

According to Needleman (in Binswanger, 1975), the actuality, possibilities and limits of psychiatry in its practice are not sufficiently clear to itself, because it rests upon two incompatible conceptual horizons. From its natural-scientific (mainly biological) horizon of understanding, its 'object' of treatment is the 'sick' organism; and, in its practice of psychotherapy, it views its object of treatment as the human being, that is, from an anthropological horizon of understanding. The situation can only be put right by going behind both conceptual horizons and grounding our understanding in the being of Dasein. It is in this regard that Heidegger's phenomenological-philosophical analytic of existence is important to psychiatry and psychology, because it does not inquire merely into the particular regions of phenomena and fact to be found 'in human beings', but, rather, inquires into the being of man as a whole (Binswanger, 1975). It is a philosophical approach that encourages the science of psychiatry and psychology to understand mankind by means of one ontological insight. It obviates the separation of mind, body and spirit.

Unlike therapies positioned in the natural scientific paradigm, an existential-phenomenological approach emphasizes understanding rather than explanation. Phenomena are kept intact to 'speak for themselves' rather than being 'atomized' to transform what is present into decontextualized representations. What distinguishes existential-phenomenological therapy from others are the attitude and intention of the therapist. Attitude and intention are perhaps best defined in terms of the difference between technique and practice. The attitude behind technique is "that we cannot trust what meets the eye and the ear … we need to devise interpretative means to decipher the phenomena" (Cohn, 2002, p. 115). But, according to Cohn, there is nothing else to look for other than what meets the eye and the ear; "practice, so to speak, (is the) other side of our beliefs" (2002, p. 116). Practice is the enactment of our beliefs, and technique becomes necessary when there is a gap between belief and enactment. This attitude (of disbelief) ushers in the intention to help a human being whilst regarding him as an organism, and results in the mechanized and dehumanizing techniques of therapy so easily recognized in the science of prescriptive psycho-therapy. In existential-phenomenological therapy, there is no technique, only understanding and the 'lighting up' of the existential structures of Dasein and its dis-ease with being-in-the-world.

The Phenomenon of Suicide

The categorical error in CBT/DBT and psycho-dynamic therapies with regard to suicide is that they are working with only the ontic manifestation of the phenomenon. Whilst their explanations, associations and correlations of the ontic appeal to reason, they fail to uncover the existential structures of this kind of existence. For Husserl, to discover the essence of phenomena - to show themselves for themselves - requires a 'bracketing' of the variants of experience (Cohn, 2002; White, 2005). But, for Heidegger, it is the very experience of Being-in-the-world that defines human existence, and understanding the essence of phenomena has to take this into account.

The phenomenology of Dasein is a hermeneutic - an interpretation. In the natural sciences, objects can be reduced to basic rules which explain why something appears, behaves or reacts the way it does, as is the wont of the therapies under discussion with their cause-and-effect arguments. But Heidegger (1927/ 1962) argues that human beings are not objects that can be understood in this manner. To understand phenomena - as they appear to humans - and to understand the nature of the phenomenon of being human in itself, requires a different method of inquiry. The method required is that of interpretation, because phenomena are not always accurate in showing themselves. A phenomenology of Dasein has to account for this and bear in mind the possible structures of a phenomenon and how it shows itself from itself. (1) Phenomena can 'seem to be', for instance a desert mirage. (2) Phenomena can 'appear to be', for instance through symptom formation. (3) Phenomena can be 'mere appearance'; for example, the categories of our perception prevent us from seeing anything outside such categories (Cavalier, 2006). These structures of phenomena nevertheless articulate or direct one to the phenomena as such, and Heidegger's phenomenology aims to wrest the phenomenon from these phenomenal plains - transcend them through interpretation - in order to arrive at phenomenological truth (transcendental

truth) (Cavalier, 2006).

There are two kinds of phenomena: ontic and ontological. "Ontological phenomena, therefore, are primary [in the order of being], but secondary in [the order of] being thought and seen" (Heidegger, 2001, p. 6). The ontological is not hidden behind the ontic, but is included in it, and our understanding has access to it even though we may not be able to articulate it, says Cohn (2002). Whatever belongs to Being as such is ontological, and whatever describes being is ontic. What the therapist encounters is ontic; it is how someone has chosen to respond to the ontological or existential 'givens' of life. "The decisive point is that the particular phenomena, arising in the relationship between the analysand and the analyst, and belonging to the respective, concrete patient, be broached in their own phenomenological content and not simply be classified globally under existentials" (Heidegger, 2001, p. 124).

Upon what basis does one attempt to gain a deeper understanding of what suicidality may mean? If suicidality is an ontic phenomenon, then Heidegger begins to reveal the ontological basis of this phenomenon when he says that the very experience of Being-in-the-world defines human existence. An understanding of the suicidal person requires an understanding of how s/he has come to exist as s/he does and how s/he has chosen to respond to the existential 'givens' of life.

The end of a person's life, when that person ceases to exist, is 'demise' and is an ontic event. Heidegger, however, does not have this in mind in his conceptualization of death. Thinking of death (demise) is the inauthentic denial of death, according to Dreyfus (in White, 2005). The ontological ground of death is anxiety, in Heidegger's view. Dreyfus quotes Heidegger: "Dasein's being … is an ability-to-be. The end or limit of this ability is the inability-to-be. The condition Heidegger calls 'death' is a limit-situation for that ability-to-be, one in which one confronts this limitation … this situation occurs when Dasein is beset by anxiety, in which none of its possibilities matters to it differentially, in which all are equally irrelevant to it" (in White, 2005, p. xix). The person may find him or herself unable to resolve the situation. It is a crisis in which Dasein cannot resolutely accept the collapse of its world, its way of life, so as to be open to disclosing a new world in which the anomalies of living existence make sense (White, 2005). This is the end of an existence, an 'existential end'.

It is argued that suicide is the ontic event which refers to this ontological 'limit situation', where the person cannot make a decision and the decision makes him. This is the person of "enclosing reserve" that Kierkegaard (1849/1983) refers to, the person who "marks time on the spot, who goes on living hour after hour but never gets beyond that", and whose "greatest danger is suicide". It means that suicide becomes the necessary fulfilment of an existence ruled by the past, leaving an empty present and its being cut off from the future. Existential ripening can only be determined by the future (Binswanger, 1958). Binswanger says that, where the life which is yet to be lived is ruled by the past, we speak of old age, but where the life-meaning of Dasein has already been fulfilled in early years, existential aging has hurried ahead of biological aging, and death is then the necessary fulfilment of the life-meaning of such an existence. This kind of limit-situation is not necessarily the either-or situation of authenticity and inauthenticity. Heidegger does not make this value judgment. He only refers to the "suffering in which the essential otherness of what-is reveals itself in opposition to the tried and usual", says Dreyfus (in White, 2005). The otherness of what-is can be experienced in both modalities of Being-in-the-world, authentic and inauthentic.

"Anxiety brings Dasein face to face with its ownmost Being-thrown and reveals the uncannyness of everyday familiar Being-in-the-world" (Heidegger, 1927/1962, p. 393). The phenomenon of anxiety is a basic state of mind (mood) and an existential structure of Dasein. It is the mood that assails one when suddenly one is confronted with the unfamiliar (uncannyness) of everyday existence. The person unexpectedly no longer feels 'at home'. It is a moment for resolution. It is a moment of confronting 'nothing', when Dasein recognizes that it is capable of re-experiencing and redefining its very own possibility to-be within the possibilities available by also Being-they. This is an uncanny place and a realization of Being-thrown from the very start. This uncanny place, or place where one does not feel at home, is the place of freedom; it is between possibility and actuality. For Kierkegaard, this freedom is anxiety or the wretchedness of spirit, a "sickness unto death". It is an unavoidable existential of the human condition, where every "moment of despair is traceable to possibility; every moment he is in despair he *is bringing* it upon himself" (1849/1983, p. 17). This leads me to the thought that suicidality may be born in a mood of fear in seeing the uncovered truth of existential loneliness. When Dasein discovers the world in its own way, it breaks up the disguises with which Dasein bars its own way; it becomes conspicuous and is no longer accommodated by the 'they' and is no longer able to misunderstand itself. Fear is a kind of mood which

colours the way in which Dasein projects itself into the future. It is a state of mind that discloses the world of Dasein in a particular mood. The meaning and significance of what is disclosed is imbued by this mood of fear. It is the ground upon which understanding takes place. "Fearing, as a slumbering possibility of Being-in-the-world in a state-of-mind, has already disclosed the world, in that out of it something like the fearsome may come close" (Heidegger, 1927/1962, p. 180). Thus, the first part of fear is that which we are afraid of, the possibility, and not the actual. It is a projecting forward onto possibilities. The second part of fear is what it is afraid about, and, in the case of Dasein, it is always for itself. The characteristic of fear is threat, says Heidegger, and, in the case of Dasein, it is threat to its existence. There are variations of fear, such as shyness, timidity or misgiving. But all "modifications of fear, as possibilities of having a state-of-mind, point to the fact that Dasein's Being-in-the-world is 'fearful'" (Heidegger, 1927/1962, p. 182). For the suicidal person, it is the growing dominance of the past over the existence which is theirs. With the supremacy of the already-been, the future becomes nonreferential. "In other words, the existence no longer finds anything there from which and by which it could understand itself … [it] exists in the mode of dread … in naked horror" (Binswanger, 1958, p. 305).

Understanding of the suicidal person requires an understanding of his or her existence, how s/he has chosen to respond to the existential 'givens' of life. Our 'thrownness' is the unchosen basis of our freedom to make choices, where one discovers that in despair one "cannot die … [Despair] cannot consume the eternal, the self at the root of despair, whose worm does not die and whose fire is not quenched" (Kierkegaard, 1849/1983, p. 18). Here I propose that we read "the eternal" in the wretchedness of spirit of Kierkegaard to mean possibility (May, 1977). It is for this reason that existential therapists, unlike those discussed, place 'time' in the centre of their attempt to understand, because "anxiety, depression, and joy, occur more in the dimension of time than space" (May, 1958, p. 65).

What people express in therapy often, then, refers to 'one's thrownness' and how the person has exercised his or her freedom and choice. Discussing choices made and choices neglected opens new possibilities once again. "This creates a place for change within therapy that, in my view, even the most meticulous reconstruction of the problem's origin does not offer" (Cohn, 2002, p. 100). With each decision, one dies and is born anew; it is to die and yet not to die, to die death. I think that 'to die death' is the anxious lingering in the uncanny, at the cusp of the kind of fear which can overcome and seemingly extinguish all possibilities. It augurs the end of an existence of misunderstanding, and it is no longer able to 'comport oneself' as it used to. Discussing choices made or neglected requires one to remember that: "Dasein is an entity which, in its very Being, comports itself understandingly towards that Being … (it is) … an entity which in each case I myself am" (Heidegger, 1927/1962, p. 78). Dasein is that Being that is mine and comports (conducts or behaves) itself towards its Being. Characterizing Dasein in this manner has a double consequence (Heidegger, 1927/1962):

(1) The essence of this entity lies in its 'to be', in other words, in its existence. A human being is a 'who', an entity that exists differently to a thing-like entity. If we are going to get to Dasein, then we have to get to it from its ownness, as opposed to examining it from the outside as another thing in the world (Waters, 2005).
(2) This existence 'that is mine' also emphasizes the responsibility that Dasein has in choosing how to comport itself towards its Being. Dasein is its possibility and it has this possibility, and because "Dasein is in each case essentially its own possibility, it *can*, in its very being, 'choose' itself and win itself; it can also lose itself and never win itself; or only 'seem' to do so" (Heidegger, 1927/1962, p. 68).

The therapeutic understanding of the phenomenon of suicidality at an existential level begins with 'a clearing' where the suicidal person finds himself marking time on the spot. It is when the three ex-stasies of human temporality (Binswanger, 1958) have fallen out of kilter - Having-been (past) and Being-with (present) outweighing being-ahead-of-oneself (future) - that the person no longer feels at home. How it has come to be like that belongs to a story of living which can only be told by those who experience it. In believing one's eyes and ears during the telling, the tale becomes a discourse of original understanding. It is within this kind of understanding-together, which does not pretend to know, that a different existential *what*, *how* and *who* can be born. We can only begin to understand suicide in the relating with another human being, and in psychology this seems to have become a very difficult thing to do.

Conclusion

In this paper, I suggest that it may have been scientific psychology that pushed Mr. Dumpty off the wall with a preconceived idea of how he should be put together again. But this, I argue, was not necessary at all, because he was sufficiently whole to

start with. As practitioners, we have become so insecure about what our eyes and ears observe that we no longer appreciate or trust the *who* in our presence. Our understanding of the nature of being human is in fragments at the base of the imposing and almost impenetrable theoretical edifice of mankind. Those we put together no longer resemble who they are. There is a disjunction between our understanding and our doing. This disjunction is most evident in the cognitive-behavioural and psychodynamic therapies of suicidality. Existential-phenomenological therapy avoids this through its reliance on one ontological insight into the nature of being human. *Who* in treatment becomes primary once again, and two people are able to meet one another as someone present. It allows for a glimpse into how we have come to misunderstand who we essentially are and the possibilities this may hold for the other. This attitude fosters a human encounter that is direct and personal, the very 'mechanism of change' valued by those who struggle with suicidal thoughts and intentions. Suicide is both problem and mystery for the therapist in practice. Problems can and should be solved, whilst mysteries cannot be. We can only relate to mysteries, dwell in them, and take part in the expressed suffering of the suicidal patient in order to console him and confirm his sense of life (Talseth, Jacobsson, & Norberg, 2000). Therapy should attempt to mix natural scientific knowledge with knowledge about a unique person. The art is to know by what quantity, and to wisely recognize when a problem is a mystery. This acknowledgement in itself is life affirmative for one in despair.

About the Author

Gabriel Rossouw holds two Master's degrees, the first in Counselling Psychology from Rhodes University in South Africa and the second in Analytical Psychology from the University of Western Sydney. In 1994, he and his family immigrated to New Zealand, where he is employed as a psychologist in a public mental health unit.

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